Commonwealth of Kentucky
Personnel Cabinet

Department of Employee Insurance
Flexible Benefits Branch
Phone: 502-564-0350
Fax: 502-564-0364

Flexible Spending Account Qualifying Event Change Form

This form is to be completed if you wish to enroll, terminate, increase or decrease your current healthcare or dependent care Flexible Spending Account election during the year. This form is *only* for those participating in the Kentucky Employees Health Plan.

☐☐☐ - ☐☐ - ☐☐☐☐ **Member's Social Security Number**	Y / N **Cross Reference (Check One)**	☐☐☐☐☐ **Agency #**	
Member's Last Name	**Member's First Name**		**M.I.**

You must experience a Qualifying Event to be permitted to make a mid-year change to your current election. Please contact your Insurance Coordinator to determine if you have a Qualifying Event. **Qualifying Event Date ___/_____/______**

Qualifying Event: (check one)

- ☐ Birth, Adoption or Placement for Adoption *
- ☐ Marriage
- ☐ Divorce, Legal Separation, Annulment
- ☐ Death of Spouse
- ☐ Child ceases to be eligible under Plan
- ☐ Death of child
- ☐ Employee, spouse or dependent terminates employment
- ☐ Loss of coverage *
- ☐ Judgment, decree or administrative order *
- ☐ Employee, spouse or dependent loses entitlement to Medicare (A or B), Medicaid, KCHIP or any governmental group health insurance coverage. *
- ☐ Significant Cost Increase or Decrease for Dependent Care *
- ☐ Spouse has different Open Enrollment period *
- ☐ Military Leave/Leave Without Pay
- ☐ Other ___________________________________

* Requires Supporting Documentation

Healthcare Flexible Spending Account	**Dependent Care Flexible Spending Account**
I request to enroll or change my healthcare FSA election from: $________ per pay period to $________ per pay period For a total *calendar year*** contribution of $________. **Calculate full calendar year amount (1/1-12/31) **Maximum Contribution - $5000 calendar year**	I request to enroll or change my dependent care FSA election from: $________ per pay period to $________ per pay period For a total *calendar year*** contribution of $________. **Calculate full calendar year amount (1/1-12/31) **Maximum Contribution based on tax filing status as checked below:** ☐ $2,500 married filing separately ; ☐ $5,000 married filing jointly; ☐ $5,000 single head of household

The effective date of the change that I have requested above will be as specified in the healthcare and dependent care Summary Plan Descriptions, which can be found at http://personnel.ky.gov/dei/09fsahra.htm

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My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract. **After signing, please give this form to your Insurance Coordinator.**

Member's Signature	Date	Insurance Coordinator's Signature	Date